LEGISLATIVE RESEARCH COMMISSION

AGING

REPORT TO THE 1985 GENERAL ASSEMBLY OF NORTH CAROLINA

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February 5, 1985

TO THE MEMBERS OF THE 1985 GENERAL ASSEMBLY

This is the Legislative Research Commission's report to the 1985 General Assembly, on the matter of the problems of aging. This report, made pursuant to House Bill 1142 (1983 Session Laws, Chapter 905), was prepared by the Legislative Research Commission's Committee on Aging and is transmitted by the Legislative Research Commission for your consideration.

Respectfully submitted,

Liston B. Ramsey
Speaker of the House

W. Craig Lawing
Senate President Pro Tempore

Cochairmen

Legislative Research Commission

TABLE OF CONTENTS

INTRODUCTION

The Legislative Research Commission, created by Article 6B of the General Assembly Statutes Chapter 120, is authorized pursuant to the direction of the General Assembly " to make or cause to be made such studies of and investigations into governmental agencies and insitutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" and "to report to the General Assembly the results of the studies made," which reports "may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations," G.S. 120-30.17. The Commission is chaired by the Speaker of the House and the President Pro Tempore of the Senate, and consists of five representatives and five senators, who are appointed respectively by the Cochairmen, G.S. 120-30.10(a). (See Appendix A for a list of the Commission members.)

Pursuant to G.S. 120-30.10(b) and (c), the Commission Cochairmen appointed study committees consisting of legislators and public members to conduct the studies. Each member of the Legislative Research Commission was delegated the responsibility of overseeing one group of studies and causing the findings and recommendations of the various committees to be reported to the Commission. In addition, one senator and one representative from each study committee were designated Cochairmen.

By House Bill 1142 (1983 Session Laws, Chapter 905), the Legislative Research Commission was authorized to continue its study of the problems of aging. In order to accomplish these tasks, Senator Russell G. Walker as a member of the Legislative Research Commission was appointed to coordinate and oversee the Study of the Problems of Aging. Senator Rachel G. Gray and Representative Gus N. Economos were appointed to co-chair the Committee. The other members appointed were Senators Ollie Harris, Marvin Ward, and Representatives Barney Paul Woodard, D. R. Mauney, Jr., Henry M. Tyson, Sidney A. Locks; and public member Dr. Monroe Gilmour. The Legislative Services Office provided staff assistance to the Committee for this study.

The minutes of the Committee meetings reflect the statements and discussions of each meeting. All of this information is included in the Committee files.

COMMITTEE HISTORY
AND
CURRENT PROCEEDINGS

The "graying" of America is not a new phenomenon; improvements in health and ensuing increases in longevity have been aging the U.S. population since the early days of the Republic. However, recent increases in the elderly population are due primarily to historical trends in birth rates and secondarily to increases in longevity. The large number of births around the turn of the century produced rapid growth in the elderly population in the 1960's and 1970's. Because there were fewer births during the 1920's and the Depression, fewer people will be joining the ranks of the elderly during the next two decades. However, people are living longer, and the number of people aged 85 and over will continue to be the fastest-growing age category. High growth rates for the total elderly population will not occur again until after the year 2010, when the baby boom generation will begin to turn 65. Then, the elderly population will increase dramatically.

Everyone aged 65 and over is classified elderly, yet the elderly are the most diverse group within the population. Their differences have been accumlated over a lifetime, and a full range of situations exists within the elderly population--rich to poor, healthy to invalid, totally independent to totally dependent, scholars to illiterates. The elderly often are perceived as needy, however, their situation has

improved dramtically over the last 25 years. In 1960, one of every three elderly Americans had an income below the poverty level. That proportion dropped to one in four in 1970 and one in seven in 1982. Disparities in income and education between the elderly and the rest of the popualtion will moderate further during the next two decades because today's middle-aged people differ little from younger people in terms of education and occupation.

Despite the overall improvements in the situation of the elderly, there are sub-groups with large unmet needs. Older women and members of minority groups, like their younger counterparts , experience a high incidence of poverty and often get less help from social groups. Existing government programs for the elderly have been characterized as ensuring that those who are poor before they turn 65 stay poor thereafter. In rural areas, access to services is a problem for many but especially difficult one for the low-income elderly. Well-being depends not only upon income but also upon the availability of the goods and services, and access becomes an extremely important variable for people as they age.

Federal income transfer programs, along with the proliferation of private sector pension plans, have reduced poverty among the elderly. Medicare and,for the low-income elderly, Medicaid both provide non-cash income and reduce the threat of economic disaster from high medical expenses. However, ten years of intermittent financing problems in the

Social Security system, rapidly increasing medical costs, and a doubling of the percent of the federal budget devoted to programs for the elderly (from 20% to over 40%) have created public concern about the economic impacts of the growing proportion of elderly people and raised questions about society's ability to maintain the programs that have contributed to a better life for the elderly since this group is most vulnerable to physical, mental, and financial crises requiring the care of their family and society.

Many persons consider the Legislative Research Commission's Committee on the Problems of Aging as a major forum for those concerned with aging in North Carolina. Thie Committee has been devoted entirely to aging, its problems, goals and aspirations. This process began in 1977 with the establishment of a House Committee on Aging. Out of this came the Legislative Research Commission's Committee on the Problems of Aging which began to meet between the two sessions of the 1977 General Assembly.

Therefore, much initial work and background has already been reported. For those interested, this information can be found in The Legislative Research Commission Report to the 1977 General Assembly, Second Session 1978 on Aging; The Legislative Research Commission Report to the 1979 General Assembly on Aging; The Legislative Research Commission Report to the 1979 General Assembly, Second Session 1980 on Aging; The Legislative Research Commission Report to the 1981 General Assembly on Aging; The Legislative

Research Commission Report to the 1981 General Assembly, 1982 Session on Aging; The Legislative Research Commission Report to the 1983 General Assembly on Aging; and the Legislative Research Commission Report to the 1983 General Assembly, Second Session 1984 on Aging. This report will detail only the information gathered by the Committee since the report to the 1983 General Assembly, Second Session 1984.

The Legislative Research Commission's Committee on the Problems of Aging held three meetings during the course of its deliberations. The meetings were held on September 25, November 29 and December 4, 1984. Again many groups and persons were heard and many issues were brought to the attention of the Committee. The following section is a compilation of those problems which need attention by the 1985 General Assembly.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 1. CONTINUE THE WORK OF THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON AGING AS BEGUN UNDER RESOLUTION 86 OF THE 1977 SESSION AS AMENDED BY RESOLUTION 106 OF THE 1977 SESSION, SECOND SESSION 1978, BY RESOLUTION 62 OF THE 1979 SESSION, BY SENATE JOINT RESOLUTION 39 OF THE 1981 SESSION AND BY CHAPTER 905 OF THE 1983 SESSION.(See Appendix B)

It is evident to the Committee that more time and effort are needed to adequately define the problems of aging and propose possible solutions. Even though having made numerous reports and recommended many bills, the Committee believes strongly that the topic of aging needs to be given top priority through the Legislative Research Commission process.

RECOMMENDATION 2. AMEND G.S. 130-9(f) TO MAKE CLEAR WHO WILL REPRESENT THE MEMBERS OF THE NURSING HOME AND THE DOMICILIARY HOME ADVISORY COMMITTEES IN CASES OF LIABILITY ARISING FROM THE EXERCISE OF THEIR AUTHORITY. (See Appendix C)

Questions have arisen regarding liability insurance for Nursing Home Advisory Committee members, and whether county governments or the Attorney General may defend them if they are sued because of actions, statements, or reports made by members while performing committee functions.

In an opinion of the Attorney General dated October 25, 1979, it was stated that Committee members were not officers because of language in G.S. 130-9.5(f)that, "Membership on a committee shall not be considered an office as defined in G.S. 128-1

or G.S. 128-1.1."

This provision was intended to exempt committee members from the law limiting persons to two offices, but it has been read more broadly by the Attorney General.

To correct the problem, the Committee recommends that the language in G.S. 130-9.5(f) be changed so that it be made clear that the Attorney General may represent these members in case of suit. The passage of this bill will negate the chilling effect of the present uncertainty.

RECOMMENDATION 3. INCREASE BY STATUTE THE PROPERTY TAX EXEMPTION FROM $8,500 to $9,500 FOR PERSONS OVER 65 AND DISABLED PERSONS. RAISE THE DISPOSABLE INCOME LEVEL FROM $9000 TO $12,000. REQUIRE THAT THE STATE BEAR 40.75% OF THE TOTAL COST. (See Appendix D)

One of the major undertakings of the Committee on Aging has been to study ways to correct the inequities in the Homestead Tax Exemption law which has been caused by the problems of inflation and property re-evaluation. The 1971 General Assembly passed this property tax homestead exemption giving low income elderly and disabled persons a reduction in property taxes. Currently the exemption is $8,500 of assessed valuation for persons who are either 65 years of age or totally and permanently disabled and whose income (including social security and pensions) is less than $9,000.

After much testimony and deliberations the Committee believes that the General Assembly should raise the exemption from $8,500 to $9,500 with a rise in the income limit

from $9,000 to $12,000. This increase would raise the present total cost from $12.1 million by $5.1 million to $17.2 million. It is recognized by the Committee that the counties and cities cannot afford to lose any more revenue and, therefore, recommends that the State assume 40.75% of the total cost.

RECOMMENDATION 4. REQUIRE BY STATUTE THAT ALL ADULT DAY CARE PROGRAMS BE LICENSED BY THE STATE OF NORTH CAROLINA.

(See Appendix G)

One of the programs that has helped older adults to remain in their homes and with their families is adult day care. It is a service for the frail elderly and disabled. It is intended to enable people to remain in their homes as long as possible and to enjoy as much independence as their condition and circumstances permit. North Carolina is viewed as a leader nationally in the quality of our standards and the role which the State has assumed in supporting the growth of adult day care.

The State Adult Day Care Fund was created by the General Assembly in 1981 with an appropriation of $390,000. This appropriation was increased to $638,000 for each year of the 1983-85 biennium. The Fund was also lucky enough to receive an additional $100,000 one-time appropriation for the 1983-84 fiscal year. There are now more than 25 certified programs in the State.

Under present conditions, if any adult day care program receives any state or federal funds, it must be certified under state regulations. But it is the fear that as adult day care becomes more popular and the chance for profit

becomes more apparent that unscrupulous operators may enter the market. The time for State licensing is now while the quality still remains high and while there are few problems.

RECOMMENDATION 5. REGULATE BY STATE STATUTE LIFE CARE RETIREMENT COMMUNITIES. (See Appendix H)

Of all the challenges facing American society, none is more dramatic than the one created by the unprecendented "age bulge" in the population. The number of Americans aged 60 and over has increased nearly sevenfold so far this century. Moreover, the number of Americans aged 65 and over is expected to approach 50 million by the year 2025, nearly double the current figure of 26 million.

One of the most critical problems facing states today is the escalating cost of long-term care for their elderly citizens. In 1982 state and local governments paid $7.1 million in total nursing home expenditures. With the aging population growing at a rate three times faster than that of the general population, the cost of caring for the elderly will continue to rise rapidly in the years ahead. In an effort to slow this steady increase in costs, many states are looking at new ways to finance long-term care for the elderly.

But cost is not the only concern. State policymakers are now recognizing that adequate long-term care means more nursing home care: it involves a coordinating system of health care, social services and housing. To meet this need, a number of states are also considering innovative models for long-term care that provide a total package of services to the elderly.

One approach gaining in popularity is the continuing care retirement community (CCRC) sometimes referred to as the life care community. This alternative to the nursing home and other forms of long-term care is increasingly attractive to many elderly because it guarantees them lifetime care as well as housing and other services. Proponents of the concept also envision life care as affordable for a large proportion of the aging population despite the widespread view that it is a viable option only for the well-to-do. A new comprehensive study of CCRCs, prepared for the Wharton School of the University of Pennsylvania, concludes that the majority of elderly citizens have the financial means to pay for life care.

The very nature of the life care arrangement, however, brings with it serious financial risk, not only for the community and its developers, but especially for the residents. For this reason state regulation is needed to insure careful financial planning of CCRCs and to protect the financial security of their elderly residents. The concept of life care was developed to meet the elderly's need for an independent way of life and to give them the security of guaranteed, affordable health care and other services. Life care is generally regarded as a kind of social and health insurance plan for the aging.

Life care facilities or continuing care retirement communities vary widely in their financing arrangements in the type of housing available and in the range of services provided. Consequently, a variety of definitions exists. Similar to other kinds of nursing homes and congregate housing for the

elderly, they provide independent living units, such as apartments or cottages, and they offer various social, recreational, maintenance, and health care services, usually on the premises. In exchange for these services, residents pay a substantial fee.

But the distinguishing feature of the CCRC is the continuing care or life care contract. Under terms of the contract, which lasts for more than one year or for life, the community promises to provide housing, health care and various services, and the resident agrees to pay, in advance, certain fees to help cover the cost of these services. Although the fees cover the cost of housing, these payments do not give the resident any ownership rights.

The earlier life care communities required residents to turn over all of their assets in return for lifetime shelter and services. Today most communities require payment of an entrance fee and a monthly service charge. According to the Wharton School study, the average entrance fee in 1981 was $35,000, with 80% in the range of $13,000 and $65,000; the monthly fee averaged $550, with most communities charging between $300 and $900. CCRCs usually vary their monthly fees on the basis of the type of housing selected and the number of occupants in each unit.

As with any type of insurance plan, the advanced funding for future services provides the financial foundation of CCRCs. The community pools the revenues it collects from residents, including entrance fees, monthly fees and Medicaid

and private insurance payments. Although residents selecting similar units will pay similar fees, the cost of providing services to them will vary since some will live longer than others and some will require more nursing care. In principle, the excess costs incurred by these residents will be covered by the reserved pool of funds received from others who need fewer services.

Life care communities are generally selective in admitting elderly individuals. Residents usually have to be a certain minimum age, have a minimum level of assets, have no pre-existing serious health problems, and be covered by Medicare and private insurance plans. The result of this selective admissions policy is that CCRC residents tend to be healthier and wealthier than the elderly in the general population.

Although a number of communities were established before the 1960s, most of them have been constructed in the last 20 years. Today there are about 300 CCRCs in the United States according to the Wharton School. Other groups using less rigid definitions, have estimated as many as 600. Estimates of the number of persons housed in CCRCs range from 55,000 to 100,000. The Wharton Study lists 8 communities in North Carolina.

The first communities were organized and sponsored by religious and charitable organizations. Today the majority are owned by nonprofit corporations, still, mostly church-related groups. Only about 5 to 10% of CCRCs are owned by for-profit institutions. But as many

as a third of the communities sponsored by not-for-profit groups are being managed by outside proprietary companies, the Federal Trade Commission reports.

In recent years high interest rates have slowed the development of CCRCs. Not only has it been difficult for developers to raise the necessary capital for construction, but potential occupants have had trouble selling their houses to obtain money for the entrance fees. But with declining interest rates and increased real estate sales, the number of new communities is expected to grow rapidly in the decade ahead. The Philadelphia accounting firm, Laventhol & Horwarth, predicts that an additional 1,000 to 1,500 communities will be in operation by 1990.

Even with the predicted growth of the life care industry, only about 2% of the elderly people are expected to reside in CCRCs by 1990. But proponents of life care see the communities as an attractive option for an even larger share of the growing elderly population. They offer certain advantages that other long-term care arrangements cannot provide. Life care represents an alternative to institutionalization for older people who can no longer maintain their own homes for both health and financial reasons, but who do not want or need the extensive care provided in a nursing home. Unlike nursing homes and other retirement communities, CCRCs give their aging residents the assurance they can live independently as long as possible and they can receive nursing care

and support services as long as needed.

Another benefit of CCRCs is that the quality of care may be better than in other types of long-term care facilities. Studies have shown that the residents of life care communities live 20% longer than the elderly population at large. They also tend to use health care resources less than the residents of comparable facilities. These favorable health status factors may be attributed to the availability of prepaid health care and other community services; they may also be influenced by the self-selection process, which reflects the better health and higher income of those choosing CCRCs.

The major advantage of life care, however, is that it is affordable to most elderly Americans, contrary to the widespread notion that only the wealthy can afford the fees. The range of fees charged by CCRCs is "within the financial grasp of the majority of individuals over age 70," the authors of the Wharton School study concluded. This may be especially true for the older communities which have paid off most of their debts and can therefore charge lower fees.

Since most elderly own their own homes, they can usually raise enough cash from selling their houses to pay the entrance fees. Social Security and private pension benefits are generally sufficient to cover the moderate and relatively fixed monthly service charges. In approximately 54% of the communities the monthly payment remains the same when the resident is transferred to the nursing facility. The monthly rate at a comparable nursing home outside the community could be considerably higher.

Another reason for the expected increase in the number

of CCRCs is that the expanding elderly population, with its financial assets, offers new business opportunities for the proprietary institutions. Although most CCRCs are owned and operated by nonprofit groups, an increasing number are under the management of for-profit corporations. In addition, more and more proprietary firms are becoming interested in developing life care communities because of the opportunities for profits and income tax savings.

As pointed out by Laventhol & Horwath in its 1982 report on the life care industry, land sales, developers' charges, construction contracts, marketing fees and management contracts can all produce profits, and depreciation of real estate investments can result in tax benefits. Among those for-profit concerns looking into the opportunities to be found in the life care business are architects, construction firms and real estate developers, as well as proprietary nursing homes and hospitals, the accounting firm said.

While the concept of life care promises financial and social security for many elderly Americans, it also poses significant financial risks. Some experts estimate that at least 10 to 20% of existing CCRCs have experienced financial difficulty or are in danger of developing serious fiscal problems in the future.

The danger lies in the considerable potential for mismanagement and fraud inherent in the unique contractual relationship between the life care community and its residents. If a community runs into financial difficulty,

because of poor financial planning or fraud, it may not be able to fulfill its commitment to the residents. The residents, having already fulfilled their part of the bargain by committing much, if not all, of their assets to the community, may be left with nothing; no shelter, no health care and no money.

The potential for financial management problems exists because of the complicated financing required to develop, construct and operate a life care community. Without careful planning and application of sound actuarial principles, a community may be doomed to failure.

Crucial to CCRCs financial solvency is its ability to calculate accurately the residents' fees, which are used to cover current and future capital and operating costs. CCRC managers must protect the costs of future health care services for the residents and then establish a pricing policy to fund that obligation, Howard Winklevoss, principal author of the Wharton School study, pointed out. They must also anticipate the costs of renovating and replacing the physical plant. Possibilities for making innocent errors during the price-setting process abound.

Mistakes are often made in projecting the resident population in the years ahead, estimating the number of deaths and the number of transfers to the nursing facility. When a resident moves to the nursing facility, the vacated apartment becomes available to a new resident, who will pay a new entrance fee. When a resident dies, the community

now has limited access to any remaining entrance fee. This reliance on turnover is a concern to some critics of the life care concept who see it as a disincentive to care for residents. But turnover of residents is essential to financial success and is the basis of establishing fees. Failure to use morbidity and mortality tables that adjust for the healthier CCRC population can result in an overestimation of the turnover rate and the setting of lower fees and consuquently, lower revenues than expected.

Another problem is failure to maintain adequate reserves. Reserve funds are needed to protect against lower turnover in the beginning and unpredictably low turnover rate in the future, as well as unforeseen capital and operating costs, high inflation rates, and the inability of residents to meet payments. Some communities may be tempted to overspend in the early years when their operating costs are low and their revenues high from the accumulation of entrance fees, attorney David Cohen, a collaborating author of the Wharton School study pointed out. Later, when the health of the residents declines, costs will increase as additional nursing care is required. The community then may not have sufficient funds in store to cover these subsequent costs because of excessive spending earlier.

A third common error is a reluctance to raise the monthly fees to make up for earlier miscalculations in the rate structure, Cohen wrote in a 1980 University of Pennsylvania Law Review article. Sometimes a community that initially charged high entry and low monthly fees may find it necessary to raise the

charge in order to increase revenues. Residents on fixed incomes, however, may not be able to afford the higher fees. In the past some CCRCs have prohibited or limited increases in a residents monthly payments. But if a financially distressed community "either cannot or will not raise its monthly fees quickly enough to make ends meet, the result is financial disaster," Cohen concluded.

The potential for fraud in the life care industry exists merely because of the community's receipt of large entrance fee payments - perhaps totaling millions of dollars in the early years of operation, before expenses mount up. During this period, a fraudulent operator could divert this money to his own use rather than setting it aside to pay for the future costs of caring for the community's residents. When the time comes to provide skilled nursing care to the residents, there may not be enough money to pay for it. Some observers believe that the likelihood of fraud has increased with the growing involvement of for-profit institutions in the operation of life care communities.

The best known example of fraud is the case of Pacific Homes, a chain of life care facilities sponsored by the Methodist Church in 1977. Pacific Homes declared bankruptcy after incurring a deficit of $27 million. This financial dilemma was the result of the diversion of substantial cash prepayments from community residents for "expansion, speculative investments and payment of current operating losses," said the report of the bankruptcy trustees. In order to pay for the care

of the residents whose funds had already been spent, the corporation had to sell more life care contracts. "The scheme continued so long as enough new people could be induced to enter into the contracts," the report concluded. Nearly 2,000 elderly people were affected by the bankruptcy.

In addition to the financial risks inherent in a life care contract, residents may be at risk because of a community's failure to provide full disclosure of its financial status. In some cases the information given to a prospective resident may not be adequate for a reasonable judgement about whether to enter into a contract. In other cases, including examples uncovered during federal investigations, the information about the community's financial condition may be intentionally misleading. One common deception found was false representation about religious affiliation, leading potential residents to believe wrongly that some church entity would bail out the community in the event of financial difficulty.

Because of this potential for mismanagement and fraud, most observers believe that some form of regulation is needed to ensure the financial viability of life care communities and to protect the welfare of the residents. Rather than a federal law for life care communities, state legislation is generally regarded as the most appropriate way to regulate the industry. The Wharton School study concluded that it would be better to encourage a variety of state legislative programs than to enact a broad federal statute since CCRCs are still relatively new and differ widely from region to region. So far 10 states

have adopted comprehensive legislation and about 6 have programs aimed at only one aspect of the industry. In a few other states, legislation is under consideration.

The Committee is convinced by the weight of the evidence presented to it that certification of life care facilities is necessary and appropriate for North Carolina. This state regulation will protect the financial security of citizens who participate in this form of long term care. Certification will also help to establish a more stable market for financing of these facilities thereby helping to foster the orderly growth of this industry in our State.

After reviewing necessary elements needed for adequate regulation of life care facilities, the Committee commends to the 1985 General Assembly the draft legislation contained in Appendix H. Although the Committee supports the general concepts contained within the bill, it recommends further refinement. The staff has been instructed to work with providers, the Department of Insurance, and others to accomplish this purpose before the convening of the 1985 General Assembly.

RECOMMENDATION 6. EXEMPT FROM INCOME TAXATION THE AMOUNT RECEIVED FROM PRIVATE EMPLOYER RETIREMENT PENSIONS NOT TO EXCEED $3000 ANNUALLY FOR PERSONS 65 YEARS AND OLDER. (See Appendix I)

The Committee believes as a matter of state policy, there should be tax equity for recipients of private pensions. There are some discrepencies in the amount of State income taxes paid on pensions according to the source of pension. For instance, if a recipient draws a pension based on service to a state or local governmental unit such as the Retirement System for Teachers and State Employees, the North Carolina Local Government Employees' Retirement Fund or the Law-Enforcement Officers' Benefit and Retirement Fund, then he pays no State income tax on these benefits. If a recipient draws a pension based on service to the federal government, then he receives an exemption of $3000, on State income taxes. But if a retiree draws a pension based on service to a non-governmental employer, then he must pay income tax.

Therefore, recipients of private plans should receive at least the same treatment as recipients of federal pensions. The needs of the private sector retirees is no less than those of public sector retirees.

The Committee believes that this issue is of such importance that it also referred this proposal to the Legislative Research Commission's Revenue Laws Study Commission.

RECOMMENDATION 7. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD APPROPRIATE $500,000 TO THE DIVISION OF AGING TO CONTINUE THE ESTABLISHMENT OF SENIOR CENTERS. (See Appendix J)

A senior center is a community focal point on aging where older persons as individuals or in groups come together for services and activities which enhance their dignity, support their independence, and encourage their involvement in and with community.

As a part of a comprehensive community strategy to meet the needs of older persons, senior center programs take place within and emanate from a facility. These programs consist of a variety of services and activities in such areas as education, creative arts, recreation, employment, health, nutrition, social services, and other supportive services. The center also serves as a community resource for information on aging, for training professional and lay leadership and for developing new approaches to aging programs.

There are presently 70 senior centers in North Carolina and they are the heart of our aging programs in this State. The Committee believes that there should be at least one senior center in each county to be a bricks and mortar focal point for the elderly. The appropriation would provide one-time grants for construction, renovation and equipment. The money would be limited to $40,000 for each center and would be supplemental to local funds.

The 1983 General Assembly (Second Session 1984) appropriated $500,000 for the senior center program but there are still 29 unfunded centers. The Committee believes than an additional $500,000 appropriation would move the State toward the goal of one senior center in each county.

RECOMMENDATION 8. ESTABLISH BY STATE STATUTE THE AUTHORIZATION FOR THE DIVISION OF AGING TO CONTINUE THE LONG TERM CARE OMBUDSMAN PROGRAM. (See Appendix K)

The 1978 amendments to the Older American Act required that the State Agency administering Older Americans Act funds (Division of Aging) must operate a statewide long term care ombudsman program. This legislation also required the appointment of a state long term care ombudsman who had the responsibility to:

1. Investigate and resolve complaints made by or for older persons in long term care facilities about actions that may adversely affect their health, safety, welfare or rights.

2. Monitor the development and implementation of federal, state, and local laws, regulations, and policies relating to long term care in the State.

3. Provide information to public agencies about the problems of older people in long term care facilities.

4. Train volunteers and assist in the development of citizen organizations to participate in the ombudsman program.

During this same period of time the North Carolina General Assembly passed legislation establishing the Nursing Home and the Domiciliary Home Bill of Rights. At the same time it called for the establishment of Nursing Home and Domiciliary Home Community Advisory Committees. The proper functioning of these Committees would not have been possible without the staff work of the ombudsman program.

The Division of Aging was charged by the General Assembly with the responsibility for providing the Committees with information, guidelines, training, and consultation to

direct them in the performance of their duties. In the fall of 1983 the Division of Aging, feeling the need to provide more support to local Committees, established a half-time regional ombudsman position in each of the eighteen area agencies on aging across the State. The persons hired for these positions were provided extensive training in order to carry out their responsibilities for working with Community Advisory Committees. This back-up to the Committees has proven invaluable in the task of providing Committee members with information and training on the wide array of topics relating to residents' rights and quality of life for nursing home and domiciliary home residents.

The interrelationship between the ombudsman program and the Advisory Committee system has been extremely beneficial to the institutionalized elderly in this State. Since the ombudsman program has no basis in state statute as does the Nursing Home and Domiciliary Home Advisory Committees, the Committee finds that it is now appropriate to recommend to the General Assembly that it also authorize ombudsman program by state statute.

The legislation included as Appendix K establishes the responsibility of the ombudsman program to:

1. Collect information on residents of long term care in North Carolina,
2. report on this information to the Secretary of Human Resources;
3. conduct complaint investigation and conciliation;
4. establish regional ombudsman to carry out his assigned duties;
5. provide access to resident's medical and personal records;

6. provide immunity from suit for good faith communication of information to ombudsman; and

7. provide immunity for ombudsman in carrying out of official duties.

APPENDICES

APPENDIX A

STATE OF NORTH CAROLINA
LEGISLATIVE RESEARCH COMMISSION
STATE LEGISLATIVE BUILDING
RALEIGH 27611

1983-1985

LEGISLATIVE RESEARCH COMMISSION MEMBERSHIP

House Speaker Liston B. Ramsey, Cochairman	Senate President Pro Tempore W. Craig Lawing, Cochairman
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Representative Bruce Ethridge	Senator Helen Rhyne Marvin
Representative Chris S. Barker, Jr.	Senator William W. Staton
Representative John J. Hunt	Senator Joseph E. Thomas
Representative Margaret Tennille	Senator Russell Walker

85W4-LF-4

A JOINT RESOLUTION TO PERMIT THE CONTINUANCE OF THE WORK OF THE LEGISLATIVE RESEARCH COMMISSION'S STUDY ON THE PROBLEMS OF AGING AS BEGUN UNDER RESOLUTION 86 OF THE 1977 SESSION AS AMENDED BY RESOLUTION 106 OF THE 1977 SESSION AND BY RESOLUTION 62 OF THE 1979 SESSION, AND AS REAUTHORIZED BY RESOLUTION 61 OF THE 1981 SESSION AND BY CHAPTER 905 OF THE 1983 SESSION.

Whereas, the aging population in North Carolina 60+ is 820,000 and presently constitutes over fourteen percent (14%) of the total population and is increasing three times faster than the State population as a whole; and

Whereas, continued inflation, rising taxes, increasing cost of medical care, inadequate institutional care facilities, insufficient pension income, forced early retirement, and lack of public awareness, have compounded the problems of the elderly; and

Whereas, these older citizens have contributed magnificently to the progress and general well being of our State and nation, and it is our concern and desire that their retirement years be a time of fulfillment rather than frustration; and

Whereas, the Legislative Research Commission Study Committee on the Problems of Aging, having made six reports, recommends that aging needs be given additional study time;

Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission, as structured by G.S. 120-30.10 et seq., may continue the study of the entire range of problems and needs of the older adults of this State and to make specific recommendations to the General Assembly on how these problems can be satisfactorily solved and met by necessary and appropriate legislative action. In its deliberations, the commission may examine national trends and programs in other states as well as programs and priorities in North Carolina. For purposes of this study, "older adult" is defined as every person who is 60 years of age or older.

Sec. 2. The membership of the Committee on Aging of the Legislative Research Commission shall consist of ten members to be appointed as follows: three senators appointed by the President Pro Tempore, three representatives appointed by the Speaker, two persons of sixty years of age or older who are not members of the General Assembly, appointed by the President Pro Tempore, and two persons of sixty years of age or older who are not members of the General Assembly, appointed by the Speaker. The Commission may report to the 1987 General Assembly and may submit an interim report to the 1985 General Assembly (Second Session 1986).

Sec. This resolution is effective upon ratification.

SESSION 19 85

INTRODUCED BY:

Referred to:

~~A BILL TO BE ENTITLED~~

AN ACT TO PROVIDE THAT NURSING HOME AND DOMICILIARY HOME COMMUNITY ADVISORY COMMITTEE MEMBERS MAY BE DEFENDED PURSUANT TO CHAPTER 143 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-128(F) is amended by adding the following new language immediately after the third sentence:

"Provided, however, that members shall be afforded the benefits of Article 31A of Chapter 143 of the General Statutes."

Sec. 2. G.S. 131D-31 is amended by adding the following sentence to the end of subsection (g):

"Members shall be afforded the benefits of Article 31A of Chapter 143 of the General Statutes."

Sec. 3. This act is effective upon ratification.

SESSION 1985

INTRODUCED BY:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE INCOME AND PROPERTY LIMITS FOR THE HOMESTEAD EXEMPTION AND TO OFFSET THE RESULTING REVENUE LOSS BY INCREASING THE PRECENTAGE OF THE HOMESTEAD EXEMPTION FOR WHICH COUNTIES AND CITIES ARE REIMBURSED.

The General Assembly of North Carolina enacts:

Section 1. G.S. 105-277.1(a), 105-277.1(b) (1), and 105-309(f) are each amended by deleting the phrase "eight thousand five hundred dollars ($8,500)" and substituting the phrase "nine thousand five hundred dollars ($9,500)."

Sec. 2. G.S. 105-277.1(a) (2) and G.S. 105-309(f) are each amended by deleting the phrase "nine thousand dollars ($9,000)" and substituting the phrase "twelve thousand dollars ($12,000)."

Sec. 3 G.S. 105-277.1A(d) is amended by deleting the phrase "fifteen percent (15%)" and substituting the phrase "forty point seventy-five percent (40.75%)."

Sec. 4. This act shall become effective January 1, 1986.

APPENDIX E

History of Property Tax
Homestead Exemption in North Carolina

Effective Year	Action
1972	First enacted by 1971 General Assembly. Exempted first $5,000 in appraised value of real property used as principal place of residence by retired owner, aged 65 years or older, whose disposable income from all sources was less than $3,500.
1974	The 1973 General Assembly substantially enlarged the class of property entitled to exclusion and raised the income eligible limit to $5,000. Also, Social Security benefits were excluded from the definition of disposable income.
1976	The 1975 General Assembly expanded eligible taxpayers to include permanent and totally disabled taxpayers regardless of age, and increased the income eligiblility limit from $5,000 to $7,500. Also, Social Security was re-included in definition of income.
1978	The 1977 General Assembly increased the exemption amount from $5,000 to $7,500 and the income eligibility limit from $7,500 to $9,000.
1982	The 1981 General Assembly increased the exemption from $7,500 to $8,500 and established a mechanism for the state to totally reimburse cities and counties for the revenue loss from the increase. However, no funds were appropriated for the reimbursement. Also, the 1981 General Assembly replaced the annual application requirement with a one-time application (unless the taxpayer's eligibility changes). The 1982 session of the General Assembly earmarked enough state tax revenue to reimburse cities and counties for the 1981 session increase.

DC:ap

APPENDIX F

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE SERVICES OFFICE
2129 STATE LEGISLATIVE BUILDING
RALEIGH 27611

ORGE R. HALL, JR
GISLATIVE ADMINISTRATIVE OFFICER
OMAS L. COVINGTON
ECTOR OF FISCAL RESEARCH
RRENCE D SULLIVAN
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FISCAL RESEARCH DIVISION
TELEPHONE 733-4910
RESEARCH DIVISION
TELEPHONE 733-2578
LEGISLATIVE DRAFTING DIVISION
TELEPHONE: 733-6660

November 8, 1984

TO: John Young
Staff, Committee on Aging

FROM: Carla Peterson CP.
Fiscal Research

RE: Fiscal Impact of Changes on the Homestead Exemption

I've listed below the proposals for the homestead exemption being looked at by the Committee on Aging and their fiscal impacts. In case the Committee decides to reimburse fully the loss in each case, I also listed the new reimbursement percentages. If you have any questions, please let me know.

Proposal # 1: Raise the exemption maximum from $8,500 to $12,000. Raise the income limit from $9,000 to $10,000.
Fiscal Loss to local governments: $6.6 million
New Reimbursement Percentage: $45.6%

Proposal #2: Raise the exemption maximum from $8,500 to $9,500 and raise the income limit from $9,000 to $12,000.
Fiscal Loss to local government: $5.1 million
New Reimbursement Percentage: 40.75%

CP:ap

SESSION 19 85

INTRODUCED BY: *

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE LICENSING OF ADULT DAY CARE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131D of the General Statutes is amended by adding the following section:

"§ 131D-6. Licensing of adult day care programs.--(a) The Department of Human Resources shall inspect and license, under rules and regulations adopted by the Social Services Commission, all adult day care programs which provide care and supervision for elderly, disabled, and/or handicapped adults on a regular but less than 24-hour basis in a place other than those adults' usual place of abode.

(b) Any individual, agency, or corporation that operates a facility subject to license under this section without having obtained the license is guilty of a general misdemeanor.

(c) The following facilities are exempted from the provisions of this section:

(1) those which care for one person only;

(2) those which care for two or more persons, all of whom are related or connected by blood or marriage to the operator of the facility;

(3) those which are required by other statutes to be licensed by the Department of Human Resources."

Sec. 2. This act shall become effective July 1, 1985.

APPENDIX H

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR CERTIFICATION OF LIFE CARE FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"Article 35.

"Certification of Life Care Communities.

"§ 58-405. Definitions.--As used in this Chapter, unless otherwise specified:

(1) 'Commissioner' means the Commissioner of Insurance of this State.

(2) 'Entrance fee' means an initial or deferred payment of a sum of money or any other consideration which assures a resident a place in a facility for a term of years or for life. An accommodation fee, admission fee, or other fee of similar form and application shall be considered to be an entrance fee.

(3) 'Facility' means any place or accommodation in which a provider undertakes to provide a resident with nursing services, medical services, health-related services, board and lodging and care as necessary, or any combination of such services, for a term in excess of one year, or for life, pursuant to a life care contract, whether such accommodation is constructed, owned, leased, rented or otherwise contracted for by the provider.

(4) 'Health related benefits' means, at a minimum, priority for nursing home admission or assistance in the activities of

daily living, exclusive of the provision of meals. Medical and nursing services and other health related benefits may be covered by the entrance fee, the periodic charges, or may be purchased at the option of the resident for an additional fee.

(5) 'Life care contract' means a contract to provide an individual for the duration of the individual's life or for a term in excess of one year, nursing services, medical services, or health-related services, board and lodging and care as necessary, or any combination of such services, for such person in a facility, which is conditioned upon the transfer of property. The transfer may include a payment of an entrance fee to the provider of services or the payment of regular periodic charges for the care and services involved, or both such payments and includes continuing care agreements.

(6) 'Provider' means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator undertakes to provide continuing care for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments.

(7) 'Resident' means a purchaser of or a nominee of, or a subscriber to, a continuing care agreement. Such an agreement may not be construed to give the resident a part ownership of the

facility in which the resident is to reside, unless expressly provided for in the agreement.

(8) 'Solicit' means all actions of a provider in seeking to have individuals pay an application fee and enter into a continuing care agreement by any means including, without limitation, personal, telephone or mail communication, or any other communication directed to and received by any individual and any advertisements in any media distributed or communicated by any means to individuals.

"§ 58-406. Duties of the Commissioner.--The Commissioner may have the authority:

(1) Prepare and furnish all forms necessary to fulfill the purposes of this Article;

(2) Establish and collect reasonable filing fees necessary to implement this Article;

(3) Adopt rules necessary to enforce this Article;

(4) Prepare and distribute information and educational materials for the public; and

(5) Impose administrative fines and penalties pursuant to this Article.

"§ 58-407. Certification requirements.--(a) No person may enter into a life care contract as a provider, or as a provider extend the term of an existing life care contract without certification obtained from the Commissioner.

(b) Each application for certification filed with the Commissioner shall contain all necessary and reasonable information that the Commissioner may by rule require to include at a minimum:

(1) The name and business address of the applicant.

and average dollar amount of each increase in periodic rates at each facility for the previous five years or such shorter period as the facility may have been operated by the provider.

(13) A statement of the terms and conditions under which a life care contract may be canceled by the provider or resident, including any health and financial conditions required for a person to continue as a resident and any conditions under which all or any portion of the entrance fee will be refunded by the provider.

(14) If construction or purchase of the facility has not yet been completed, a statement of the anticipated source and application of the funds to be used in such purchase or construction, including all of the following:

a. An estimate of the cost of purchasing or constructing and equipping the facility, including such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs which the provider expects to incur or become obligated for prior to the commencement of operations.

b. An estimate of the total entrance fees to be received from residents upon completion of occupancy.

c. A description of any mortgage loan or other long-term financing intended to be used for the financing of the facility, including the anticipated terms and costs of such financing.

d. An estimate of any funds which are anticipated to be necessary to fund start-up losses and to assure full performance of the obligations of the provider pursuant to life care contracts,

including but not limited to, any reserve fund escrow required by this Article.

(15) Certified financial statements of the provider, promoter, and administrator as of a date not more than 90 days prior to the date the permit application is filed, which shall include a balance sheet and the related statements of income, retained earnings or equity and changes in financial position for the three most recent fiscal years or such shorter period of time as the provider, promoter, or administrator have been in existence. Each of these statements shall be prepared in accordance with generally accepted accounting principles and reported upon by a certified public account in accordance with generally accepted auditing standards. If the fiscal year ended more than ninety days prior to the date of filing, the provider shall include an income statement, which need not be certified, covering the period between the date such fiscal year ended and a date not more than 90 days prior to the date the application is filed.

(16) A feasibility study which shall include a financial forecast of the life care facility which is an estimate of the most probable financial position, results of operations, and changes in financial position for the immediately succeeding 13-year period. The study shall include all of the following:

a. Beginning cash balance, and in the event that operation of the facility has not yet commenced, the beginning cash balance shall be consistent with the statement of anticipated source and application of funds described in subsection 14.

b. Anticipated earnings on cash reserves.

c. Estimates of net receipts from entrance fees, other than entrance fees included in the statement of source and application of funds required under subsection 14, less estimated entrance fee refunds and a description of the actuarial basis and method of calculation for the projection of entrance fee receipts.

d. An estimate of gifts or bequests, if any, are to be relied on to meet operating expenses.

e. A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged, including a description of the assumptions used for calculating the effect on the income of the facility of subsidized health services to be provided pursuant to the life care contracts.

f. A projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses, and separate allowances for the replacement of equipment, and furnishings and anticipated major structural repairs or additions.

g. An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing.

(17) An actuarial study prepared by an independent consulting actuary for the purpose of determining that the project has sufficient revenues and funds, including reserves, for the project to continue as a viable operating concern.

(18) In the event that the feasibility study required by subsection 16 indicates that the provider will have cash balances over and above two months' projected operating expenses of the

facility, a description of the manner in which the reserve funds will be invested and the persons who will be making the investment decisions.

Nothing in this Article is deemed to require the Commissioner to determine the actual financial condition of any life care contract provider. The approval of a permit indicates only that the entity appears to be financially viable based upon the information provided to the Commissioner.

(c) Certification shall be granted to the applicant upon a determination by the Commissioner that the applicant has complied with the provisions of this Article and the rules adopted under this Article.

(d) A certification to operate a facility shall be annually renewed upon the filing and the Commissioner's approval of the renewal application. The renewal application shall be available from the Commissioner and shall contain all necessary and reasonable information that the Commissioner may by rule require.

(e) Each certification shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the written approval of the Commissioner.

"§ 58-408. Adverse action on a certification.--(a) Subject to subsection (b), the Commissioner shall have the authority to deny a new or renewal application for certification and to amend, recall, suspend, or revoke an existing license upon a determination that there has been a substantial failure to comply with the provisions of this Article or the rules promulgated under this Article.

(b) The provisions of Chapter 150A of the General Statutes, the Administrative Procedure Act, shall govern all administrative action and judicial review in cases where the Commissioner has taken the action described in subsection (a).

"§ 58-409. Escrow; collection of deposits.--(a) As a condition for certification under this Article, the Commissioner shall require that a provider establish an escrow account with a bank, trust company, or other escrow agent approved by the Commissioner. The terms of this escrow account shall provide that all of any entrance fee received by the provider prior to the date the resident is permitted to occupy a living unit in the facility be placed in escrow with a bank, trust company, or other escrow agent approved by the Commissioner, subject to the condition that such funds may be released only as follows:

(1) If the entrance fee applies to a living unit which has been previously occupied in the facility, the entrance fee shall be released to the provider at such time as the living unit becomes available for occupancy by the new resident.

(2) If the entrance fee applies to a living unit which has not previously been occupied by any resident, the entrance fee, or that portion of the entrance fee not to be held in escrow pursuant to this Article, shall be released to the provider at such time as the Commissioner is satisfied that all of the following conditions exist:

a. Construction or purchase of the facility has been substantially completed and an occupancy permit covering the

living unit has been issued by the local government having authority to issue such permits.

b. A commitment has been received by the provider for any permanent mortgage loan or other long-term financing described in the statement of anticipated source and application of funds submitted by the provider as part of its permit application, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied.

c. Aggregate entrance fees received or receivable by the provider pursuant to binding life care contracts, plus the anticipated proceeds of any first mortgage loan or other long-term financing commitment are equal to not less than 90 percent of the aggregate cost of constructing or purchasing, equipping and furnishing the facility plus not less than 90 percent of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of its permit application, to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to life care contracts.

(b) If the funds in an escrow account required to be established under subsection (a) are not released within such time as provided by rules issued by the Commissioner, when such funds shall be returned by the escrow agent to the persons who had made payment to the provider.

(c) An entrance fee held in escrow may be returned by the escrow agent to the person who made payment to the provider at any time upon receipt by the escrow agent of notice from the

will be provided for a designated time period or for life. The contract shall designate the classes of resident, if any.

(3) Describe the procedures to be followed by the provider when the provider temporarily or permanently changes the resident's accommodation within the facility or transfers the resident to another health facility. A resident's accommodations shall be changed only for the protection of the health or safety of the resident or the general and economic welfare of the residents.

(4) Describe the policies that will be implemented in the event the resident becomes unable to meet the monthly fees.

(5) State the policy of the provider with regard to changes in accommodations and the procedure to be followed to implement that policy in the event of an increase or decrease in the number of individuals occupying an individual unit.

(6) Provide in clear and understandable language, in print no smaller than the largest type used in the body of the agreement, the terms governing the refund of any portion of the entrance fee in the event of discharge by the provider or cancellation by the resident.

(7) State the terms under which an agreement is canceled by the death of the resident.

(8) Provide in clear and understandable language, in print no smaller than the largest type used in the body of the agreement, whether or not monthly fees, if charged, will be subject to periodic increases.

principal and interest payments due during the next 12 months on account of any first mortgage loan or other long-term financing obligation of the facility. Requirements on reserve escrow funds established in subsection (a) shall apply.

"§ 58-411. Removal of records or assets from State.--No records or assets of the provider related to the operation of the facility and the provision of services under the life care contract shall be removed from this State by a provider unless the Commissioner consents in writing to such removal. Such consent shall be based upon the provider submitting satisfactory evidence that the removal will facilitate and make more economical the operations of the provider and will not diminish the service or protection thereafter to be given the provider's residents in this State.

" 58-412. Required provisions of the life care contract.--(a) In addition to such other provisions as may be considered proper to effectuate the purpose of any life care contract, each agreement executed between a resident and a provider shall:

(1) Show the total consideration paid by the resident according to the terms of the life care contract, including the value of all property transferred, donations, entrance fees, subscriptions, monthly fees, and any other fees paid or payable by or on behalf of a resident.

(2) Specify all services such as food, shelter, medical care, nursing care, or other health services, which are to be provided by the provider to each resident, including in detail all items which each resident will receive, whether the items

provider that such person is entitled to a refund of the entrance fee.

"§ 58-410. Reserve fund escrow.--(a) The Commissioner shall, as a condition of the certification, require that the provider maintain on a current basis in escrow with a bank, trust company, or other escrow agent approved by the Commissioner, an amount which equals the aggregate principal and interest payments due during the next 12 months on account of any first mortgage or other long-term financing of the facility. The principal of the escrow account may be invested with the earnings thereon payable to the provider, and up to one-sixth of the total principal shall be released to the provider upon notice to the Commissioner. The escrow agreement shall provide that upon withdrawal of any such amount by the provider, the escrow agent shall provide immediate written notice of such withdrawal to the Commissioner and that any amount released to the provider shall be repaid to the escrow account within two years of the release of such amount. In the event that the provider does not repay the escrow account within such two-year period, the escrow agent shall provide immediate written notice to the Commissioner.

(b) In those instances where a provider has been offering life care contracts in a facility established prior to January 1, 1982, the following shall apply. The provider shall establish a reserve escrow fund and shall contribute 15 percent of each new entrance fee received by the provider after January 1, 1986. The funds thereby received shall be permitted to accumulate until there is in the reserve fund an amount equal to the total of all

(9) Provide that charges for care paid in advance in one lump sum only shall not be increased or changed during the duration of the agreed upon care.

(10) Give a description of the living quarters.

(11) State the conditions, if any, under which a unit may be assigned to the use of another by the resident.

(12) State the religious or charitable affiliations of the provider and the extent, if any, to which the affiliate organization will be responsible for the financial and contract obligations of the provider.

(13) State the resident's and provider's respective rights and obligations as to use of the facility and as to real and personal property of the resident placed in the custody of the provider.

(14) State what, if any, fee adjustments will be made in the event the resident is voluntarily absent from the facility for an extended period of time.

(15) Specify the circumstances, if any, under which the resident will be required to apply for Medicaid, Medicare, public assistance, or any public benefit program.

(b) This section shall not apply to any continuing care agreements entered into prior to January 1, 1986.

(c) Any agreement submitted to the Commissioner which does not contain the above disclosures shall be returned to the facility for amendment. No certification shall be issued by the Commissioner unless and until the agreement meets the requirements of this subsection.

"§ 58-413. Disclosure statement contents.--At the time of or prior to the execution of a life care contract and the transfer of any money or other property to a provider, the provider shall deliver to the individual with whom the life care contract is entered into a disclosure statement which contains a copy of the life care facility's certified financial statements and feasibility study prepared according to the provisions of G.S. 58-407 and any other information required by the Commissioner. The cover of the disclosure statement shall contain the following statement in bold-faced print, 'A certification for this life care facility has been issued by the North Carolina Department of Insurance. This certificate does not constitute approval, recommendation or endorsement of the life care facility by the Department.'

"§ 58-414. Recession of agreement.--(a) The individual with whom a life care contract is entered into shall have the right to rescind the life care contract within ten days without penalty, after making an initial deposit or executing the contract, and after receipt of a copy of the disclosure statement, whichever is last received. During the ten-day period the individual's funds shall be retained in a separate escrow account under terms approved by the Commissioner. The individual shall not be required to move into the facility before the expiration of the ten-day period.

(b) If an applicant for admission to a facility withdraws the application prior to execution of a life care contract, the applicant shall receive a full refund of all moneys paid to the provider except a processing fee approved by the Commissioner.

"§ 58-415. Discharge of resident prior to expiration of agreement.--No agreement for care shall permit dismissal or discharge of the resident from the facility providing care prior to the expiration of the agreement without just cause for such a removal and without providing advance notice of at least 60 days. If a facility terminates a resident for just cause, the facility shall pay to the resident a refund equal to the entrance fee divided by the resident's years of expected lifetime at admission multiplied by the resident's year of expected lifetime at discharge or dismissal. Years of expected lifetime shall be computed for both purposes on the basis of the life tables most recently published by the U.S. Department of Health and Human Services at the time of discharge or dismissal.

"§ 58-416. Waiver of certain provisions prohibited.--No act, agreement, or statement of any resident or by an individual purchasing care for a resident under any agreement to furnish care to the resident shall constitute a valid waiver of any provisions of this Article intended for the benefit or protection of the subscriber or the individual purchasing care for the resident.

"§ 58-417. Penalties.--Any person who violates any provision of this Article or who willfully fails to perform any act required or who willfully performs any act prohibited by this Article, shall be guilty of a misdemeanor and upon conviction shall be punished by a fine or by imprisonment for a period not to exceed two years or by both such fine and imprisonment in the discretion of the court; provided, however, that any person who willfully

violates any rule adopted by the Commissioner under this Article or who willfully fails to perform any act required by, or who willfully performs any act prohibited by, these rules shall be guilty of a misdemeanor and upon conviction shall be punished by a fine not to exceed fifty dollars ($50.00) or by imprisonment for a period not to exceed 30 days.

"§ 58-418. Actions for recovery of damages or equitable relief.--(a) Any resident injured by a violation of this Article may bring an action to the recovery of damages in any court of general jurisdiction. In such cases the court may award reasonable attorney's fees to a resident in whose favor a judgment is rendered.

(b) Any resident injured by a violation of this Article, or the Commissioner on behalf of any resident, may institute an action for an appropriate temporary restraining order or injunction."

Sec. 2. This act shall become effective January 1, 1985.

N16-28

A BILL TO BE ENTITLED

AN ACT TO PROVIDE A PARTIAL EXCLUSION FROM INCOME FOR RETIREMENT PAY RECEIVED BY AN ELDERLY TAXPAYER FROM A PRIVATE EMPLOYER RETIREMENT PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. G.S. 105-141(b) is amended by adding a new subdivision to read:

"(30) The amount, not to exceed three thousand dollars ($3,000), received by an individual, who is aged 65 or over as of the last day of the taxable year, from one or more private employer retirement programs to which the individual made contributions during his working years."

Sec. 2. This act is effective for taxable years beginning on or after January 1, 1985.

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FUNDS FOR SENIOR CITIZENS' CENTERS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Human Resources, Division of Aging, the sum of five hundred thousand dollars ($500,000) for fiscal year 1985-86 to provide one-time grants for the construction, renovation, and equipping of Senior Citizens' Centers. These grants shall be limited to no more than forty thousand dollars ($40,000) per center, provided that each center matches not less than twenty-five percent (25%) of the grant's value with local resources.

Sec. 2. This act shall be effective July 1, 1985.

APPENDIX K

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A LONG-TERM CARE OMBUDSMAN PROGRAM

The General Assembly of North Carolina enacts:

Section 1. Chapter 143B of the General Statutes is amended by inserting a new section to read:

G.S. 143B-181.10. The Long Term Care Ombudsman Act: There shall be established in the North Carolina Division of Aging a long-term care ombudsman program.

A. Definitions. - As used in this Chapter, unless otherwise specified.

(a) 'Assistant Secretary' means the Assistant Secretary on Aging, Department of Human Resources

(b) 'Facility' means a long term care facility licensed under Chapter 131E or under Chapter 131D

(c) 'Ombudsman' means a person or persons responsible for carrying out the duties of the long-term care ombudsman program

(d) 'Regional ombudsman' means a person employed on a regional basis and certified by the N. C. Division of Aging to carry out the duties of the long-term care ombudsman program.

(e) 'Resident' means an individual kept, cared for, treated, boarded or otherwise accommodated in a facility

B. The state ombudsman shall:

(1) Establish policies and procedures, subject to approval by the Secretary of Human Resources, for receiving, investigating, referring, and attempting to resolve complaints made by or on behalf of residents of long-term care facilities concerning any act, omission to act, practice, policy, or procedure that may adversely affect the health, safety, or welfare of any resident;

(2) Investigate and make reports and recommendations to the department and other appropriate agencies concerning any act or failure to act by any government agency with respect to its responsibilities and duties in connection with long-term care or residents of long-term care facilities;

(3) Establish a uniform state-wide reporting system to record data about complaints and conditions in long-term care facilities and shall collect and analyze such data in order to identify significant problems affecting the residents of such facilities;

(4) Promote the development of regional ombudsmen activities and provide technical assistance as necessary; and

(5) Make an annual written report, documenting the types of complaints and problems reported by residents, to the Assistant Secretary of Aging for recommendations to the Secretary of the Department of Human Resources concerning needed policy and regulatory and legislative changes.

C. Pursuant to policies and procedures established by the state ombudsman, the regional ombudsmen shall:

(1) Learn about the general conditions affecting residents of long-term care facilities and work for the best interest of these residents;

(2) Receive, investigate, and attempt to resolve complaints made by or on behalf of residents of long-term care facilities;

(3) Collect data about the number and types of complaints handled; and

(4) Report regularly to the state ombudsman about the data collected and the activities of the regional ombudsmen.

D. (a) Following an investigation, the state ombudsman or regional ombudsman shall report his opinions or recommendations to the party or parties

affected thereby and shall attempt to resolve the complaint using, whenever possible, informal techniques of mediation, conciliation, and persuasion. With respect to a complaint against the long-term care facility, the ombudsman shall first notify the administrator of the facility in writing and give such administrator a reasonable opportunity to correct any alleged defect. If the administrator fails to take corrective action after a reasonable amount of time or if the defect seriously threatens the safety or well-being of the residents, the state ombudsman or regional ombudsman shall refer the complaint to an appropriate agency.

(b) Complaints or conditions adversely affecting residents of long-term care facilities which cannot be resolved in the manner described in subsection (a) of this section shall, whenever possible, be referred by the state ombudsman to an appropriate agency.

(c) The regional ombudsman shall not disclose to the public, either directly or indirectly, the identity of any long-term care facility which is the subject of an investigation unless and until the matter has been reviewed by the state ombudsman and the matter has been referred to an appropriate governmental agency for action.

E. Entry to facilities and access to patients

(a) An ombudsman is hereby authorized to enter any facility and any area within such facility at any time with or without prior notice and shall have access to the residents of a facility at all times.

(b) An ombudsman shall notify immediately the person in charge of a facility upon arrival and shall present appropriate identification.

F. Access to records and documents;

An ombudsman shall have access to records and documents kept for or concerning a resident. In addition, in assisting a resident of a facility, an ombudsman shall have access to all records and documents of the facility which are relevant to such assistance. An ombudsman shall have access to books, records and other documents maintained by the facility to the extent necessary to carry out the provisions of this act. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "`Public records` defined." Prior to releasing any information or allowing any inspections referred to in this subsection, the patient must upon admission be advised in writing by the facility that the patient has

the right to object in writing to the release of information or review of the records and that by an objection in writing the patient may prohibit the inspection or release of the records.

G. Confidentiality

All information, records and reports received by or developed by an ombudsman which relate to a resident of a facility, including written material identifying a resident, are confidential and shall not be disclosed or released by an ombudsman except upon the order of a court or with the written release of the resident or the legal representative of the resident. This shall not prohibit the communication of information to other agencies under the same legal obligation of confidentiality when it is in the best interest of the health or welfare of the resident.

H. Notwithstanding any other provision of law, no person providing information, including, but not limited to, patient records, to the state ombudsman or a regional ombudsman shall be held, by reason of having provided such information, to have violated any criminal law or to be civilly liable under any law unless such information is false and the person providing such information knew or had reason to believe that it was false.

I. Any person who, in good faith, makes a complaint or provides information as authorized in this article and any state or regional ombudsman who, in good faith, makes a statement or communication relevant to a complaint received or an investigative activity conducted pursuant to this article shall incur no civil or criminal liability therefor.

J. The Secretary of the Department of Human Resources is authorized to adopt and promulgate rules and regulations to implement this article.

Section 2. This act shall be effective upon ratification.